ATTACHMENT 1
EYE TEST CERTIFICATION

NAME:	EMPLOYEE Z No./(SSN if unavailable):

TEST WITHOUT CORRECTIVE LENSES	**NEAR DISTANCE**	**FAR DISTANCE**
1. RIGHT EYE O.D. (COVER LEFT EYE)	_____	_____
2. LEFT EYE O.S. (COVER RIGHT EYE)	_____	_____
3. BOTH EYES O.U.	_____	_____

TEST WITH CORRECTIVE LENSES

TYPE OF CORRECTION USED (e.g., READING, BIFOCAL) : _____

	NEAR DISTANCE	**FAR DISTANCE**
1. RIGHT EYE O.D. (COVER LEFT EYE)	_____	_____
2. LEFT EYE O.S. (COVER RIGHT EYE)	_____	_____
3. BOTH EYES O.U.	_____	_____

TYPE OF TEST

NEAR DISTANCE ☐ JAEGER ☐ OTHER _____

FAR DISTANCE ☐ SNELLEN ☐ OTHER _____

COLOR ☐ ISHIHARA ☐ PSEUDO-ISOCHROMATIC PLATES

HAS THE APPLICANT DISTINGUISHED THE APPROPRIATE RANGE AND NUMBER OF COLOR PLATES TO VERIFY NORMAL COLOR VISION? ☐ YES ☐ NO

IF APPLICABLE, WHAT COLOR(S) IS THE APPLICANT DEFICIENT IN? _____

REMARKS: _____

_____.

I CERTIFY THAT THE RESULTS RECORDED ARE THOSE FROM THE EYE EXAMINATION ADMINISTERED TO:

Examiner Name: _____ **Z#:** _____

Signed: _____ Title: _____ Date: _____

Based on the recorded test results, the above applicant has satisfactorily passed the examination for vision certification.

Signed _____ Title: _____ Date: _____

RESPONSIBLE MANAGER/LEVEL III